Medicaid Reform for North Carolina

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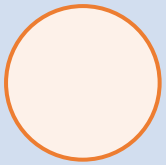
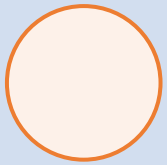
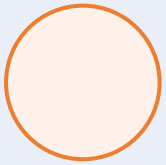
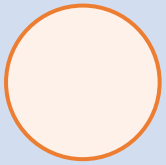
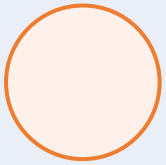
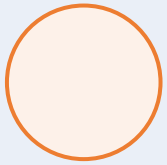
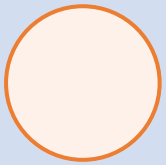
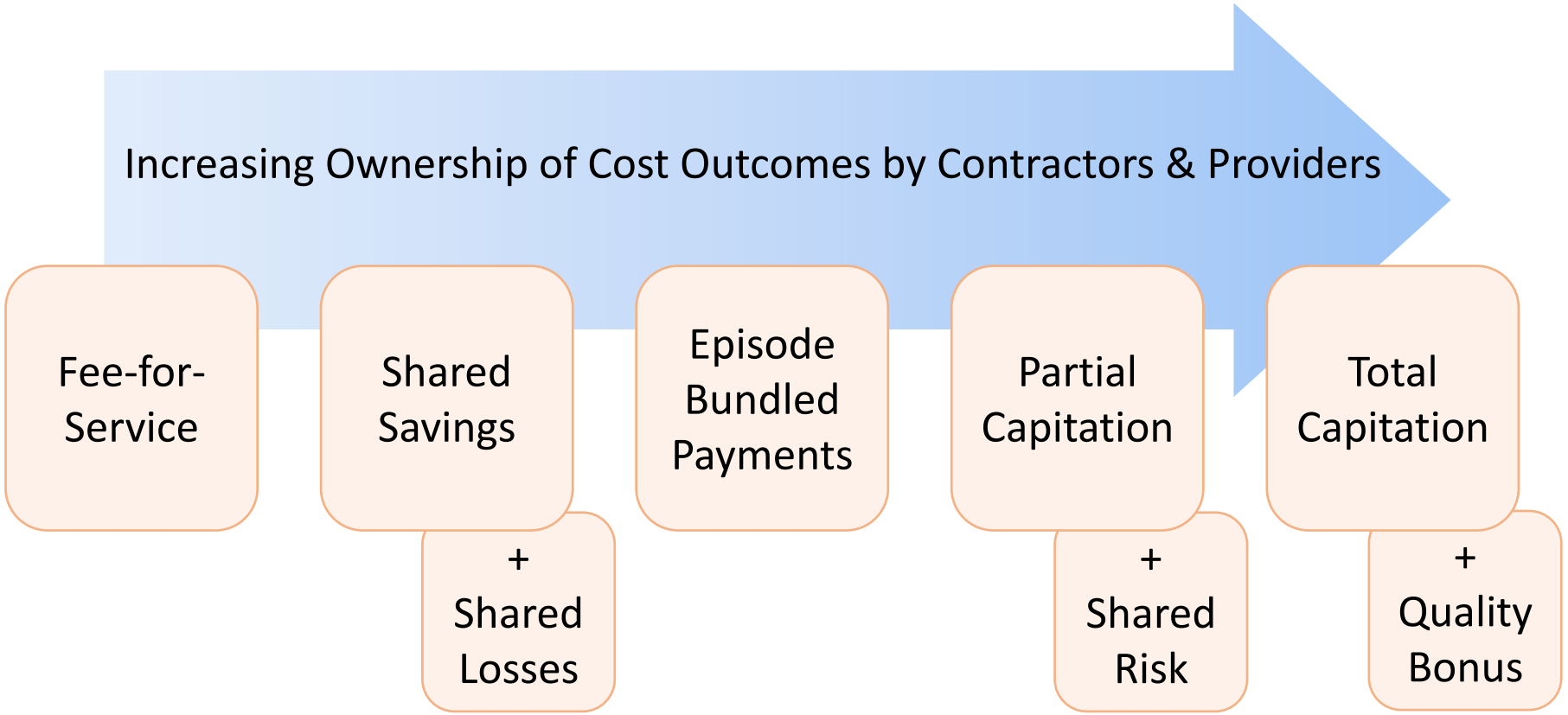
Medicaid Reforms in Other States

Medicaid Models' Effectiveness Varies

Goal	Unmanaged Fee-for-Service	PCCM/FFS with Care Coordination	Risk-Based Managed Care
State's Medicaid Budget More Predictable			
Beneficiaries More Assured of Access & Care Coordination			
Opportunity for Whole-Person Integrated Care			
Contractor At Risk for Per Capita Medical Costs			
Responsibility for Care Quality & Outcomes Localized			

PCCM = Primary Care Case Management

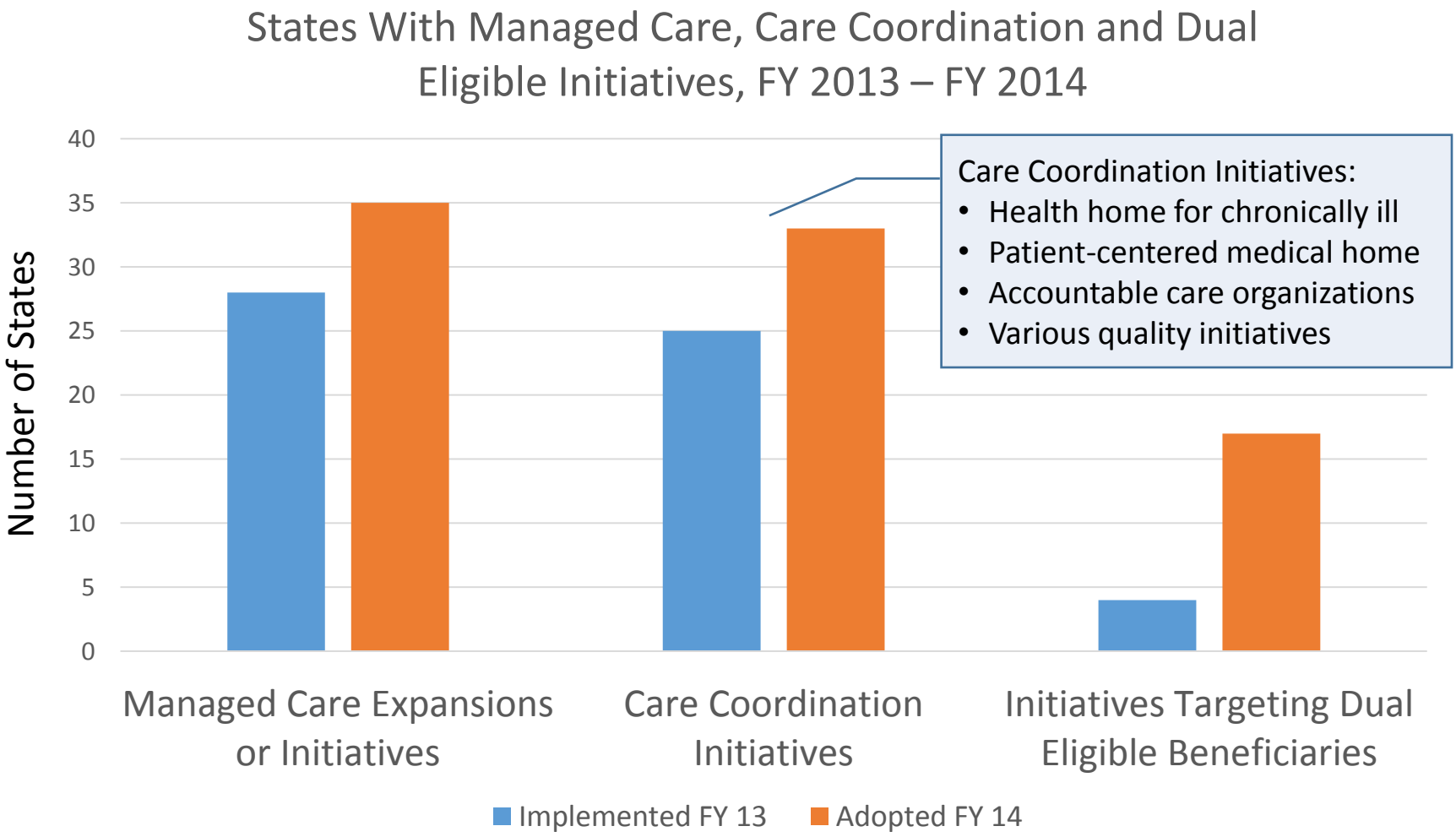
Ways To Transfer Health Cost Risk



Risk under capitation can be buffered

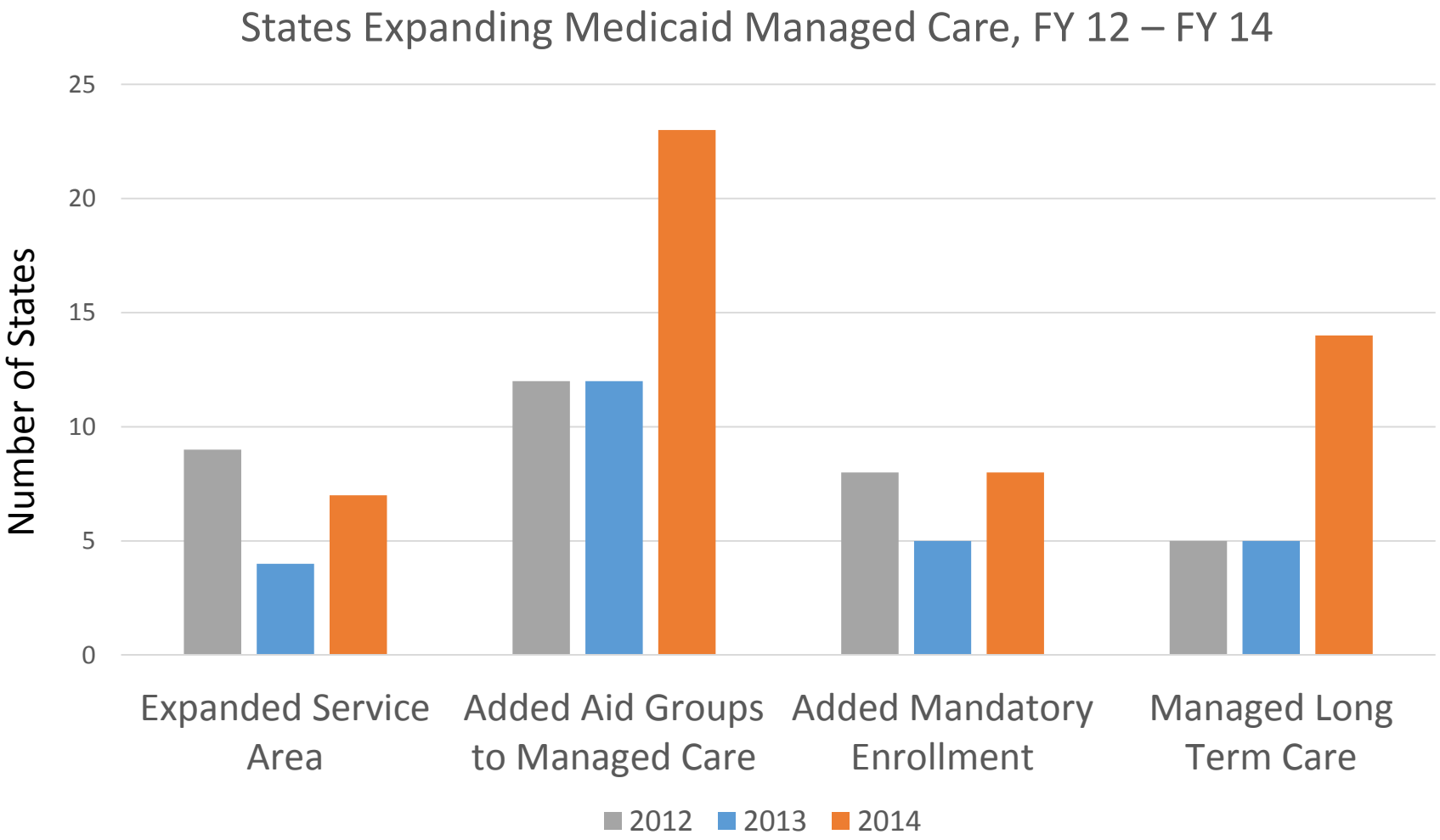
- Risk adjustment of capitation rates
- Stop-loss for high-cost cases

Nearly All States Are Pursuing Reform



Source: Kaiser Commission on Medicaid & Uninsured survey of states conducted October 2013

States Increase Use of Managed Care



Source: Kaiser Commission on Medicaid & Uninsured survey of states conducted October 2013

Big 12 States' Risk Transfer Progress

Total Spend Rank	State	% Spend Capitation (2010)	Risk Contracting Changes Since 2010
1	NY	24%	Moving to capitate nearly all spending
2	CA	21%	Broadening risk contracts to elderly & rural
3	TX	22%	Moving to capitate nearly all spending
4	FL	22%	Moving to capitate nearly all spending
5	PA	50%	Changing PCCM to capitation in rural areas
6	OH	33%	Adding capitation for dual eligibles
7	IL	2%	Restructuring for 50% capitated by 2015
8	MI	55%	Adding capitation for dual eligibles
9	MA	35%	Adding capitation for dual eligibles
10	NC	2%	Capitation of behavioral care, imaging
11	AZ	85%	Unchanged
12	TN	69%	Capitation for long-term care population

Source: Menges Group analysis of CMS data from 2010, plus Menges & Avalere Health research on recent state changes

Nearby States' Risk Transfer Progress

Total Spend Rank	State	% Spend Capitation (2010)	Risk Contracting Changes Since 2010
15	GA	35%	Moved foster children to risk plans
19	VA	31%	Expanded to more counties
24	KY	16%	Broad move to capitation plans in 2012
25	SC	27%	Shifted 80k more beneficiaries in 2011
26	AL	17%	Moving globally to capitation by 2016
29	MS	0%	Legis. to shift 45% to capitation plans

Source: Menges Group analysis of CMS data from 2010, plus Menges & Avalere Health research on recent state changes

Florida – Design Features

- Major components
  - PCCM model (MediPass)
  - Capitation contracting with MCO
  - Shared Risk contracting with Provider Sponsored Networks (PSNs)
- Enhanced managed care pilot in 2006 in several counties; goals included:
  - Comprehensive choice counseling
  - Customized benefit packages
  - Enhanced benefits for participating in healthy behaviors
  - Risk-adjusted premiums based on enrollee health status
- Introduced managed LTSS program in south Florida in 2006 and expanded statewide in 2013
- Expanded capitated program statewide via 2013 procurement
  - Eliminates MediPass PCCM program
  - Awarded specialty plans in each region
  - Provider service network had preference in each region (at least one slot)

Florida – Observations

- Florida has good mix of insurer-sponsored and provider-sponsored MCOs
- Recent procurements also spurred partnerships:
  - In MLTSS program, some broad-based MCO applicants teamed with specialty long-term care coordination entities and behavioral health entities
  - In the acute care program, some PSNs teamed with insurer-based organizations with providers retaining over 50% ownership)
  - Many acute care program applicants teamed with behavioral health organizations, dental vendors, transportation vendors, etc.
- The managed care pilot initiative produced an annual savings of $118 million during from 2006-2010

Maryland – Design Features

- Started Medicaid coordinated care program in late 1980s, using both a PCCM approach and an MCO risk contracting program
- PCCM discontinued in 1997, replaced with large-scale MCO contracting program (HealthChoice)
  - PCCM model had not saved money or lowered emergency department usage
  - Used application process to contract with all qualified MCOs (no “losers”)
- Division of state into regions helped foster provider-sponsored MCOs
- Behavioral health services were carved out of MCO capitation, contracted to separate BH care manager
- Program designed to extensively measure quality and motivate improvement
  - Annual “report card” compares MCOs on several measures
  - MCOs financially rewarded/penalized based on quality indicators

Maryland – Observations

- State achieved a mix of insurer and provider-sponsored MCOs
  - HealthChoice MCOs have been highly stable throughout past 16 years
- Strong increases in physician participation have been documented
- CMS-approved assessment of budget neutrality showed savings of several billion dollars since HealthChoice's inception
- Consensus that HealthChoice has succeeded in improving access and quality, and in providing beneficiaries an effective medical home

Tennessee – Design Features

- Enrolled entire Medicaid population into full-risk managed care in 1994, Medicaid program was renamed “TennCare”
- Moved from full-risk contracting with MCOs to administrative services only (ASO) non-risk contracting and back to full risk
- Since 2009, has required all Medicaid MCOs to be NCQA-accredited
- Currently procuring contracts with 3 statewide MCOs
  - Model fully integrates physical health, behavioral health, and long-term care services (with exception that pharmacy is carved out of capitation)
  - Pushing MCOs to achieve stronger provider integration

Tennessee – Observations

- HEDIS scores have risen – gains in 88% of HEDIS measures tracked since 2006, and in 31 of 41 measures introduced more recently
- Enrollee satisfaction reached 95% in 2011 and has steadily increased from 61% in 1994
- Annual per capita medical cost trends have been 3% - 4% from 2011-2013, below both national Medicaid and commercial insurance norms
- Program evolved from dealing with volatile, poorly capitalized health plans to more stable, well-capitalized contractors

Virginia – Design Features

- Early 1990s: implemented Medallion, a Medicaid coordinated care program using both PCCM and MCO risk contracting
- Medallion II (1996) mandated MCO enrollment for select groups
  - 2005: dental carved out
  - 2006: ABD eligibles in certain counties were allowed to enroll in the program
- Each county had choice of Medallion II or Medallion PCCM until PCCM was phased out in 2012
- July 2013, proposed enhanced “Medallion 3.0” program
  - Gain/loss-sharing
  - Risk-adjusted quality metrics
  - Quality incentive payment tied to monthly capitation
  - Consumer-driven care
- Behavioral health carve-out program is about to be implemented

Virginia – Observations

- Virginia has seen improved outcomes through every program edition
  - Better medical outcomes
  - Stronger physician-patient relationships
  - Improved access to preventive care and extensive use of patient education
  - Reduced inappropriate use of medical services
- Complaints for Medallion II very low
- Dental carve-out led to higher dentist participation in Medicaid and improved access to dental care for beneficiaries
- Consensus that MCOs provide a far stronger array of support services than the State is willing/able to administer
  - Member education, outreach
  - Provider credentialing and training, web support, phone responsiveness
  - Quality measurement and NCQA accreditation

Specialized Programs For High-Need Subgroups Are Growing Rapidly

- 23 states have implemented Medicaid managed LTSS programs
  - 11 states have implemented their programs since 2012
  - Some states with longstanding programs have recently expanded MLTSS initiatives (e.g., Florida and New York)
- Behavioral health services for high-need enrollees are increasingly being included in Medicaid coordinated care programs
  - North Carolina is an example of a BH-only model – many other states contract directly with behavioral health coordinated care organizations (examples include Arizona, Connecticut, Maryland, and Pennsylvania)
  - Several states are designing capitation programs that fully integrate physical and behavioral health services for high-need subgroups (e.g., Florida, Ohio, Tennessee, Texas)

States Can Promote Provider Sponsorship of Medicaid Plans

- Licensure rules can explicitly encourage provider-sponsored plans (e.g., provider-sponsored network model in Florida)
- Geographic coverage requirements – via regional division – can support formation of localized programs
- Procurement scoring can directly reward provider ownership, in-state ownership, etc.

Emerging Vision for NC Medicaid Reform

Population and Geography

- Distinct approaches based on population groups' needs
  - Mental health, developmental disability, substance abuse
  - Long-term services and supports
  - All others
- Regional division
  - Allow for local solutions and variation across state
  - Regions designed based on health care usage patterns

Organizations to Be Engaged

- Leverage LME-MCOs for MHDDSA
- Specialized plans focused on LTSS
- Coordinated care plans for general needs

  Level playing field for those that meet specifications …
  - Home-grown provider-sponsored networks
  - Established managed care organizations
- CCNC

Financial and Quality Provisions

- Every payment type along risk continuum
  - Progression over time to more risk transfer
- Measures to preserve existing safety net supplements
- Incentives for improving care quality and outcomes
- Transparency on money flows and performance metrics
- Monitoring and assurance that appropriate care is rendered